IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

July 26, 2007

Jennifer Lyn Davis, Administrator
Mallory House
3400 S 5th West
Idaho Falls, ID 83402

License #: RC-534

Dear Ms. Davis:

On April 20, 2007, a complaint investigation, state licensure survey was conducted at Mallory House. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Maureen McCann, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Maureen McCann RN

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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May 9, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0797

Jennifer Lyn Davis, Administrator
Mallory House
3400 S 5th West
Idaho Falls, ID 83402

Dear Ms. Davis:

Based on the complaint investigation, state licensure survey conducted by our staff at Mallory House on **April 20, 2007,** we have determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period more than 30 days. The facility also failed to protect residents from inadequate care. Based on observation, interview, and record review, it was determined the facility failed to update an NSA to describe how the residents' needs would be met for 1 of 7 sampled residents (#3). The facility also failed to develop an NSA to identify and describe residents' behavior management needs for 2 of 7 sampled residents (#2, #3).

These core issue deficiencies substantially limit the capacity of Mallory House to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **June 4, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **May 22, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**May 22, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **May 22, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **May 20, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Mallory House.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Carolyn McMurtrey, RN, Program Manager, Regional Medicaid Services, Region VII - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R534	A. BUILDING _____ B. WING _____	04/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLORY HOUSE	3400 S 5TH WEST IDAHO FALLS, ID 83402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard/complaint survey conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Maureen A. McCann, RN Team Coordinator Health Facility Surveyor Polly Watt-Geier, MSW Health Facility Surveyor Sydnie Braithwaite, RN Health Facility Surveyor Survey Definitions: BMP = Behavior Management Plan NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument	R 000		
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator. This Rule is not met as evidenced by: Based on interview, observation and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period more than 30 days. Review of the facility's records on 4/18/07, revealed the current administrator was the same administrator over another licensed facility.	R 004		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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R 004	Continued From page 1 Further review of the facility's correspondence on 4/18/07, revealed a letter to the Licensing and Survey agency notifying them of an administrator change at the facility. However, there was no documented evidence the facility had requested an administrator variance to allow the current licensed administrator to oversee two licensed buildings. On 4/18/07 at 9:42 a.m., the current administrator stated the former administrator was no longer the facility administrator as of 2/05/07. She stated a letter had been sent to the Licensing and Survey agency notifying them of her becoming the administrator over the facility. She also stated that her license was over both licensed facilities and she had not applied for an administrator variance. The facility had operated for more than 30 days without a single licensed administrator responsible for the day-to-day operations.	R 004		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to update an NSA to describe how the residents needs would be met for 1 of 7 sampled residents (Resident #3). The facility also failed to develop an NSA to identify and describe residents behavior management needs for 2 of 7 sampled residents (Residents #2 and #3). The findings	R 008		

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R 008	Continued From page 2 include: I. Updated the NSA. 1. Review of Resident #3's record on 4/18/07 revealed the resident was admitted on 12/31/06 with diagnoses which included dementia, atrial fibrillation, and hypertension. Resident #3's record contained a UAI dated 3/08/07, which documented the resident needed "physical assistance with parts of the toileting task such as wiping, cleansing, clothing, adjustment. May need a protective garment." Additionally, it documented the resident was incontinent of urine, wore attends, and staff would change the attends for him. Review of Resident #3's record revealed an NSA (undated) which documented the resident was independent in toileting. Resident #3's record contained "Resident Service Notes" which documented the following: On 2/12/07 at 10:30 p.m., the resident needed assistance with changing into clean, dry attends. On 2/16/07 at 4:30 a.m., the resident was confused and disoriented and was not wearing an attends. On 3/28/07 on the night shift, resident wandering out in the hall in his underwear and had feces on his hands and shirt. On 4/13/07 (untimed), resident was found attempting to urinate in the hallway. He was directed to his room where he urinated next to his	R 008		

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R 008	Continued From page 3 door. On 4/16/07 on the night shift, the resident's room was found to have "liquid all over the bathroom floor". On 4/18/07 between 8:35 a.m. and 9:50 a.m., Resident #3's room was observed to have small brown stains on the carpet near his closet. On 4/19/07 at 5:05 p.m., the resident was observed to have a wet spot on the front of his gray pants that was approximately 6" by 5". Additionally, there was a pink chair in the resident's room that had a brown substance on the seat cushion in the shape of a hand print. The carpet underneath the chair had approximately an 8" stain that saturated the carpet. The room also had a strong odor of feces and urine. On 4/19/07 at 4:27 p.m., the facility nurse confirmed the resident should be on a scheduled toileting program. She also stated she was not aware the resident had been smearing feces. On 4/19/07 at 6:18 p.m., a caregiver stated that resident had been declining mentally over the last month. The caregiver also stated he had redirected the resident to the bathroom over the past two weeks. The caregiver stated the resident needed to be toileted every three hours. On 4/20/07 at 8:34 a.m., the facility administrator stated the resident needed assistance with toileting and he needed to wear attends. On 4/20/07 at 8:57 a.m., a housekeeper stated the resident had been wiping feces in his room and it was an ongoing issue.	R 008		

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R 008	Continued From page 4 On 4/20/07 at 9:03 a.m., a second caregiver stated the resident had lost control over his bowel movements, and sometimes he would remove his attends and hide them. She stated the resident would notify staff when he needed to urinate The facility did not update Resident #3's NSA to ensure his toileting needs were being met. II. BMP 1. Review of Resident #3's record on 4/18/07 revealed the resident was admitted on 12/31/06 with diagnoses which included dementia, atrial fibrillation, and hypertension. Resident #3's record contained a UAI dated 3/08/07, which documented that resident may wander outside and may also wander into other residents' rooms at night. Review of Resident #3's record revealed an NSA (undated) which documented that the resident had "Sundowners" (experiencing increased memory loss later in the day and into the evening) and wandered at night. There was no documented evidence of a BMP. Review of the facility's incident and accident reports on 4/19/07 revealed an incident dated 1/23/07 at 9:00 p.m., where the resident had wandered into another resident's room. The other resident pushed Resident #3 out of his room and shut the door. Resident #3's record contained "Resident Service Notes" which documented the following: On 1/03/07 at 2:00 p.m., the resident had been "walking into other rooms cause he doesn't	R 008		

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R 008	Continued From page 5 know where his is. Some residents express their fear of him going into their rooms". On 1/05/07 at 6:00 p.m., a caregiver found the resident at another resident's room and the resident was "totally confused". The caregiver took resident back to his own room. On 1/23/07 at 10:00 p.m., the caregiver observed the resident was "wandering into several residents' rooms this shift. Resident also wandered outside via kitchen door. About 9 p.m. resident wandered into 119's room". On 1/25/07 at 10:00 p.m., a caregiver noted the resident had wondered out an exit door near room 117. On 1/31/07 at 9:45 p.m., a caregiver noted the resident was "wandering in peoples' rooms". On 2/01/07 (untimed), a caregiver noted that the resident was "found last night @ 10:00 p.m. in the hall sleeping, standing up". On 3/15/07 on the night shift, a caregiver noted the resident wandered into another resident's room. On 3/28/07 on the night shift, a caregiver noted the resident was "wandering the halls in his underwear and trying to go in rooms". On 4/19/07 at 4:10 p.m., Resident #7 stated the following: "A man tried to get into my room and he scratched and scratched at my door. Used call bell. He couldn't get in because he doesn't have my key. Staff came and got him". On 4/19/07 at 5:06 p.m., the exit door near room	R 008		

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R 008	Continued From page 6 117 was observed to lead outside to an unsecured area. The kitchen door was also observed to lead outside to an unsecured area. On 4/19/07 at 6:18 p.m., a caregiver stated the resident needed redirection because sometimes he would go into the other residents' rooms and the other residents would yell or call for assistance. On 4/20/07 at 8:34 a.m., the facility administrator stated the resident had tried going out the kitchen door "a couple of times" and staff had to redirect him back to the dining room. The exit door off of the kitchen was locked after the resident tried to leave through this door. On 4/20/07 at 9:03 a.m., a second caregiver stated that other residents had told her that Resident #3 had wandered and they "just don't like it". The facility did not develop an NSA to include a BMP for Resident #3's inappropriate behaviors. 2. Review of Resident #2's record on 4/18/07, revealed the resident was admitted on 1/28/07 with diagnoses which included Alzheimer and intracerebral hemorrhage. Review of Resident #2's record revealed an NSA (undated), which documented the resident did not "currently have any behavior issues that require monitoring." Resident #2's record contained a nursing assessment dated 1/30/07. Under a section entitled, "Behavioral/Psycholosocial Issues" documented the resident had anxiety and agitation. It also documented the resident was	R 008		

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R 008	Continued From page 7 "very confused and agitated." Resident #2's record contained an "Elopement Risk Assessment" dated 1/30/07. It documented the resident was a "high risk for elopement." Resident #2's record contained a fax to the resident's physician dated 2/14/07, which documented the resident "became combative with staff when showering, hitting, kicking, and shouting, please advise." Resident #2's record contained "Resident Services Notes" which documented the following behaviors: On 2/3/06 at 10:00 p.m., the resident became combative "smacking" the staff while they assisted her with toileting. On 2/6/07 (untimed), Resident #2 tore her attends in bed and when a caregiver was assisting the resident in the shower, Resident #2 hit the caregiver and pulled the caregiver's hair. On 2/24/07 at 3:00 p.m., the resident "set the fire alarm off this morning by pulling the fire alarm handle. She was trying to get out of the front door." On 3/17/07 on the night shift, the resident "was spotted in the hallway at 4:00 a.m., yelling for her significant other. She was redirected and put back to bed." On 3/19/07 at 2:00 p.m., Resident #2 became "aggressive" and hit a caregiver on the back. Resident #2 "was also threatening to bust down the front door if we didn't let her out."	R 008		

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R 008	Continued From page 8 On 3/19/07 at 9:10 p.m., the resident "became aggressive when it was time to have 7pm medications." Resident #2's record contained hospice nursing notes, which documented the following: On 2/6/07 between 10:25 a.m. and 11:35 a.m., "staff stated the resident had increased agitation this am and became a bit physical." On 2/9/07 between 1:10 p.m. and 1:50 p.m., "staff stated the resident had some increased agitation in the am and at times physical." On 2/16/07 at 12:30 p.m. and 1:15 p.m., the resident was given a shower, "was ok did get agitated. Re-directed and she did ok. She did not have her hair washed, family was ok with this." On 3/30/07 between 3:15 p.m. and 3:50 p.m., the nurse noted the resident had "episodes of agitation". On 4/18/07 at 3:36 p.m., the administrator stated the resident is occasionally aggressive with staff. The resident does have a significant other who assisted to reduce her anxiety and aggression. She confirmed the facility had not been tracking the resident's behaviors and did not have a BMP as her behaviors had been decreasing. On 4/19/07 at 8:22 a.m., the hospice nurse stated the resident could become physically aggressive during showers. They have worked with the resident on reducing the behaviors and now shower her in the afternoon when her significant other is with her at the facility. The hospice nurse also stated since the interventions with showering, the resident had become less	R 008		

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R 008	Continued From page 9 aggressive. The facility did not develop an NSA to include a BMP for Resident #2's inappropriate behaviors. The facility did not develop an NSA to include BMP's which included all situations that triggered Residents #2 and #3's inappropriate behaviors and failed to provide guidance to personnel in their provision of care and services to meet the needs of residents.	R 008		

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May 9, 2007

Jennifer Lyn Davis, Administrator
Mallory House
3400 S 5th West
Idaho Falls, ID 83402

Dear Ms. Davis:

On April 20, 2007, a complaint investigation survey was conducted at Mallory House. The survey was conducted by Polly Watt-Geier, MSW, Sydnie Braithwaite, RN and Maureen McCann, RN. This report outlines the findings of our investigation.

Complaint # ID00002148

Allegation #1: The facility was not serving palatable food to the residents.

Findings: On Aprl 18, 2007 through April 19, 2007 from 8:35 a.m. to 5:01 p.m., thirteen random residents and two family members were interviewed. They stated there was no variety of meal items offered. However, there were no complaints that the food was not palatable.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Findings #2: On Aprl 18, 2007 at 10:25 a.m., the facility's menus were observed to be signed and dated by a registered dietician. Additionally, a daily menu was observed hanging beside the signed menu, which differed from what the registered dietician had selected for the scheduled menu.

Allegation #2: The facility had not been following the scheduled menu.

Findings: On Aprl 18, 2007 at 10:27 a.m., the kitchen manager stated she did not follow the scheduled menu because she was instructed to developed the daily menu to follow the residents' preferences.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.01.d for not following the scheduled menu. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility was not assisting with medications as scheduled and the as needed (PRN) medications were sometimes not passed when requested.

Findings: Review of seven resident records between Aprl 18, 2007 and April 19, 2007 revealed no documented evidence that medications were not given as scheduled or that PRN medications were not passed when requested.

On Aprl 18, 2007 through April 19, 2007 from 8:35 a.m. to 5:01 p.m., thirteen random residents and two family members were interviewed. They stated there had not been any delay in scheduled or PRN medications.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

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May 9, 2007

Jennifer Lyn Davis, Administrator
Mallory House
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Dear Ms. Davis:

On April 20, 2007, a complaint investigation survey was conducted at Mallory House. The survey was conducted by Polly Watt-Geier, MSW, Sydnie Braithwaite, RN and Maureen McCann, RN. This report outlines the findings of our investigation.

Complaint # ID00002333

Allegation #1:	The facility did not complete an investigation when a resident had an unexplained injury.
Findings:	The resident's facility closed record, hospital and home health records were reviewed April 18, 2007. There was no documented evidence that the facility was aware of the injury until it was discovered in the ER on December 6, 2006. Interviews on April 19, 2007 at 3:00 p.m. and 4:25 p.m. and on April 20, 2007 at 9:21 a.m. with two caregivers and the facility's registered nurse revealed staff were not aware of the injury prior to December 6, 2006.
Conclusion:	Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.
Allegation #2:	The facility did not obtain timely medical services for a resident.
Findings:	On April 18, 2007, the identified residents closed record was reviewed. On December 4, 2006 a home health nurse documented the resident's respirations were non-labored, regular, and that breath sounds were clear and the resident did not have a cough. The first notation regarding a cough by facility staff was dated December 6, 2006. Home health was notified that day and documented the resident's respirations were labored, irregular, and that breath sounds had gurgles and the resident had a productive cough. The resident was transported to the emergency room on December 6, 2006.
Conclusion:	Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: The facility did not assist the resident with medications as prescribed by the physician due to letting a family member administer medication to the resident.

Findings: Telephone interview with the resident's family member on April 19, 2007 at 5:42 p.m. revealed the resident received cough syrup brought in to the facility by the family member without a physician's order.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not assuring there was a current physician's order for a medication the resident received. Refer to non-core punch list. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: The facility staff did not assure the resident's catheter tubing was positioned correctly.

Findings #4: On April 18, 2007 the resident's closed record was reviewed. A plan of care update note dated November 24, 2006 documented the resident was complaining of the catheter hurting and pinching. A daily skilled nursing note dated November 28, 2006 documented that the resident complained of pain and the foley was found to be kinked and not draining properly. Another plan of care update note dated November 29, 2006 documented the resident stated the catheter was pinching. Interviews on April 19, 2007 at 3:00 p.m. and on April 20, 2007 at 9:21 a.m. with two caregivers revealed caregivers had not received foley care training by the facility nurse.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.08 for the facility nurse not accessing, documenting and recommending foley catheter care education for facility staff. Refer to non-core punch list. The facility was required to submit evidence of resolution within 30 days.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. and/or Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Maureen McCann, RN

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Mallery House	3400 S. 5th West	(208) 528-6599
Administrator	**City**	**ZIP Code**
Jennifer Davis	Idaho Falls	83402
Survey Team Leader	**Survey Type**	**Survey Date**
Maureen McCann RN	Standard / Complaint Invest.	4/20/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	225.01.c	The facility did not document residents' #2, 3, 5 & 6 behaviors to include intensity, duration and frequency.	5/23/07 MMC	
2	225.02.a	The facility did not consistently implement interventions for residents' #5 6 behaviors.	5/23/07 MMC	
3	260.06	The facility did not maintain the interior of the facility in a clean & safe manner, i.e. carpet stains rooms 109, 119, 121 & dining room. The following resident rooms had a strong urine odor: rooms 139, 109 and the hallway & strong fecal odors in the hallway & room 109; strong unidentified foul odor in room 128. A love seat in Salem hallway had brown streak on cushion approx. 4 inches long. room 109 had a mauve-colored chair which had hand-shaped brown stain.	3 6/22/07 MMC And outside rooms 107, 119 near corner near room 125	

Response Required Date	Signature of Facility Representative	Date Signed
5/20/07	Jennifer Davis	4-20-07

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Survey Team Leader	**Survey Type**	**Survey Date**
Maureen McCann RN	Standard / Complaint Investigation	4/20/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
4	305	the facility RN did not complete a nursing assessment on resident #3.	5/23/07 MMc	
5	305.05	the facility RN did not follow up on a previous recommendation for a mental health referral for resident #5 which had the potential to affect the health and safety of the resident.	5/22/07 MMc	
6	305.06	the facility RN did not conduct an initial nursing assessment for residents to self-administer; ie, rooms 101, 111, 115, 121, 124, 126, 131, 132 and 135.	5/23/07 MMc	
7	320.03	the facility did not assure that the NSA was signed and/or dated by the resident or resident's legal guardian (residents # 2 & 3) OK 6/21/07 MMc OK 5/23/07 MMc		

Response Required Date	Signature of Facility Representative	Date Signed
5/20/07	Jennifer Davis	4-20-07

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NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
8	405.03	The facility did not assure that oxygen tanks were properly restrained per NFPA Standard 99, Standard for Health care facilities, 2003 edition. (rooms #123 and 128).	5/23/07 mm	
9	450	The facility did not meet the food safety and sanitation standards for food establishments. i.e. the dishwasher person did not sanitize their hands between handling dirty and clean dishes.	5/23/07 mm	
10	451.01.d	The facility did not serve the planned menu.	5/22/07 mm	
11	711.01	The facility did not document when a specific behavior occured or intervention that were used, or effectiveness of the interventions for residents #2, 3, 5, and 6.	5/23/07 mm	
12	711.08.e	The facility's care notes did not include notification to the RN for Residents #3, 5 & 6's regarding changes in their mental condition	5/24/07 mm	

Response Required Date	Signature of Facility Representative	Date Signed
5/20/07	Jennifer Davis	4-20-07

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Survey Team Leader	**Survey Type**	**Survey Date**
Maureen A McCann RN	x Standard / Complaint	4/20/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
13	30502	The facility did not assure there was a current MD order for a/medication (Cough Syrup) Resident # 8 received.	5/24/07 MMc	
14	305.08	The facility RN did not assess, document + recommend catheter care, education/needs for facility staff for Resident # 8's foley catheter.	5/24/07 MMc	

Response Required Date	Signature of Facility Representative	Date Signed
5/20/07	Jennifer Davis	4-20-07